Summary of Community Support Changes

Modification of the Community Support Definition is needed to:

- Address the requirements of the Session Law 2007-323, Section 10.49(ee). This section of the Appropriation Bill outlines community support requirements. During the last legislative session, The General Assembly enacted this provision as a result of growing concerns regarding the quality of the service, the preliminary results of audits and reviews conducted or authorized by DHHS and rapid expansion and growth of the service.
- Address the findings of Community Support Clinical Post Payment Reviews
- Address the DMA/DMH observations during and as a result of the review of questions received during the 7 Access To Care Training Sessions conducted in July, August and September.
- Address the quality of the service delivered
- Clarify the intent of the service
- Correct the abuse of the service

Most changes were made in both the adult and child definitions. Differences are due to: legislative mandates, review of data, review of utilization patterns of providers serving children and adults, and EPSDT requirements.

Adult - Community Support	**Child – Community Support**
Reduces the 8 unmanaged (no prior approval required) community support hours for new consumers to 4 hours. Outlines that only the qualified professional level component may be provided during the unmanaged hours without prior approval. The purpose of the unmanaged hours is to complete the person centered plan to determine additional services or hours needed and to submit the plan for prior approval.	Maintains the 8 hours of unmanaged (no prior approval) community support hours for new consumers. Outlines that only qualified professional level services may be provided during the unmanaged hours in order to complete the person centered plan. Any provision of community support by an Associate or paraprofessional or any additional hours of community support requires prior approval prior to the delivery of service.
Emphasizes that Community Support is a rehabilitative, treatment service that is needed to address the MH/SA diagnosis and symptoms associated with the diagnosis.	Emphasizes that Community Support is a rehabilitative, treatment service that is needed to address the MH/SA diagnosis. It is not a social support service, recreational program or a mentoring/ big brother program.
Establishes a benefit limit of 780 units for	Due to EPSDT requirements, hard benefit

up to 90 days. Eliminates the exception process for granting more than 780 units. This is referred to as a hard limit.	limits may not be established. As a result of EPSDT, a "soft limit" of 780 units is used to trigger a more in-depth clinical review as part of prior authorization. In addition to units, other examples of triggers include certain diagnoses or use of community support in schools, etc.
Emphasizes the requirement of the clinical assessment to support the Person Centered Plan and that the PCP drives the delivery of Community Support. By receiving Community Support Service, clinical outcomes are achieved.	Emphasizes the requirement of the clinical assessment to support the Person Centered Plan and the PCP drives the delivery of Community Support. By receiving Community Support Services, clinical outcomes are achieved.
Clarifies the expected clinical outcomes for the service	Clarifies the expected clinical outcomes for the service
Clarifies and modifies the activities that are billable as Community Support	Clarifies and modifies the activities that are billable as Community Support
Clarifies the role and allowable functions of the Qualified Professional and the Associate/Paraprofessional	Clarifies the role and allowable functions of the Qualified Professional and the Associate/Paraprofessional
	Adds the requirement for the Child and Family Team to be a part of the PCP process
Notifies the provider of the expectation to follow Implementation Memos, Medicaid bulletins, Rules, DMH/DD/SAS Service Record Manual and all Medicaid requirements prior to billing the service	Notifies the provider of the expectation to follow Implementation Memos, Medicaid bulletins, Rules, DMH/DD/SAS Service Record Manual and all Medicaid requirements prior to billing the service
Notifies the provider of the expectation to refer to other appropriate services and providers in order to provide the most appropriate treatment service to the recipient	Notifies the provider of the expectation to refer to other appropriate services and providers in order to provide the most appropriate treatment service to the recipient
Requires a minimum of 25% Qualified Professional Services per recipient	Requires a minimum of 25% of Qualified Professional Services per recipient
Requires that the during the first 10 hours of CS, 50% of the delivery must be by QP to ensure proper development,	Requires that during the first 10 hours of CS that 50% of the service shall be delivered by QP to ensure proper

implementation and monitoring of the plan	development, implementation and monitoring of the plan
Notifies the provider of the QP/AP modifier requirement for billing	Notifies the provider of the QP/AP modifier requirement for billing
Refines the Entrance, Continued Stay and Discharge Criteria. Such as requires the interventions and the PCP to be based on acceptable community standards and treatment practices such as American Academy of Child and Adolescent Psychiatry and American Psychiatric Association Practice Guidelines.	Refines the Entrance, Continued Stay and Discharge Criteria. Such as requires the interventions and the PCP to be based on acceptable community standards and treatment practices such as American Academy of Child and Adolescent Psychiatry and American Psychiatric Association Practice Guidelines, a higher level or alternative service is not needed, increases from 1 to 2 areas of documented evidence of symptoms
Highlights the minimum documentation requirements for progress note documentation	Highlights the minimum documentation requirements for progress note documentation